Urgent & Emergency Care Attendances
January 2018 Commentary

Executive Summary

The NHS Improvement Chief Executive wrote to trusts on 13th October 2017, which resulted in some trusts altering reporting in two ways:

a) Including non-co-located Type 3 attendances in their own returns
b) Including "new pathways of care" in their returns.

The UK Statistics Authority subsequently raised concerns. An assessment exercise has now raised questions over the inclusion of up to 26,000 pathways of care per month in October, November and December 2017. It is estimated that national A&E performance in previous months could have therefore been affected by between 0.11 to 0.18 percentage points.

NHS trusts have themselves confirmed that none of this "new activity" was included in performance reporting for January and February.

Background

NHS Improvement wrote to NHS providers on 13th October 2017 on the topic of reporting A&E performance. The letter covered two main areas. Firstly, it outlined how non-co-located type 3 services would be mapped to Type 1 providers to produce additional insight into trusts' A&E performance – helping compare performance on a more "like for like" basis between trusts that run local Walk-In-Centres and those that don't.. Secondly it asked the NHS to begin reporting new pathways of care, such as direct admissions to ambulatory care units, within their submitted A&E performance on a consistent basis.

As a consequence of this letter a number of NHS trusts started reporting new activity; both new UEC pathways and Type 3 activity that was previously reported separately by community providers. This resulted in artificially inflated growth in A&E attendances and, in some cases, the double counting of A&E activity.

On 22nd January 2018, the UK Statistics Authority (UKSA) wrote to express concerns over the impact the correspondence may have had on the Accident and Emergency Attendances and Admissions statistics published each month.

In light of the letter from the UKSA, NHS Improvement issued a follow up letter on 25th January 2018. Within this letter, NHS providers were asked to not report any new UEC pathways in the monthly A&E return, but rather report them to a new collection on UEC Pathways which would not be included in published A&E performance figures. The letter also re-confirmed that trusts should not report the non-co-located activity – this would be attributed at a later date with no impact on headline national performance.

NHS England sent a letter to the UK Statistics Authority, dated 7th February 2017. This confirmed that "for the avoidance of doubt, none of this newly reported activity

should be included in official performance calculations at present," and committed to assessing whether trusts had been incorrectly submitting data in previous months in response to NHS Improvement's original letter.

Details of this assessment process can be found in Annex A.

Assessment findings: Attributing type 3 attendances

Many trusts with a Type 1 A&E have a co-located Type 3 A&E service. Those trusts without a co-located Type 3 service often have a Type 3 nearby. Attributing the attendances of the nearby Type 3s to the relevant local Type 1 A&E service creates a better "like with like" comparison between major A&E providers. The attribution is either as agreed at local A&E delivery board level or is based on using SUS to split type 3 provider activity to relevant type 1 providers

The full attribution is available here: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2017-18/

It should be noted that the allocation of Type 3 activity has no impact on A&E performance at a national level. Performance also continues to be reported *without* attribution, so the public has access to both sources of information.

Assessment findings: New pathways of care

For January 2018, 139 acute trusts providing A&E services were asked to complete a return detailing any new pathways which they believed warranted consideration for inclusion in future A&E performance figures. In total 124 trusts submitted a return, but of these 61 were a NIL return. The remaining 63 submitted details of at least one UEC pathway.

In many instances submitting trusts took the opportunity to provide more granular information about traditional Type 1 to Type 4 A&E pathways. In total just over 50,000 urgent and emergency care pathways were identified.

The UEC Pathways service can be grouped into 3 main categories (table 2). The largest category in terms of reported services is Ambulatory Care/Assessment Units (63 services), However, Hot Clinics account for the most patient pathways (16, 914).

Table 1

Service Description	Total	
	Attendances	Services
Ambulatory Care / Assessment Units / CDUs	17,338	63
Direct Admissions to Wards	16,190	28
Gynaecology, Maternity & Hot Clinics	16,914	48
Other	52	1
Total	**50,494**	**140**

Just under half of the newly emerging attendances, 24,000 attendances, were reported for the first time in this new return. The remaining 26,000 attendances were confirmed by the reporting trusts as being in one or more of the prior months' A&E returns.

Table 2

	Attendances	Services
Previously Submitted	26,107	61
Not Previously Submitted	24,387	79
Total	**50,494**	**140**

There are nearly 2m A&E attendances per month. Table 3 below estimates the potential impact on national performance in previous months.

Table 3: Potential Impact of UEC Pathway previously reported

	Attendances		Performance		
	Original	**Estimated**	**Original**	**Estimated**	**Difference**
October 17	2,061,874	2,035,767	90.03%	89.92%	-0.11 p.p.
November 17	1,991,271	1,995,164	88.85%	88.72%	-0.13 p.p.
December 17	2,016104	1,995,462	85.07%	84.90%	-0.18 p.p.

NHS trusts have themselves confirmed that none of this "new activity" was included in performance reporting for January and February.

Next Steps

The UEC Pathways collection will continue in order to collect further information to feed into the wider review of how new care pathways should be captured and reported.

Annex A

Current Process

NHS providers are asked to submit data to the monthly A&E attendances and admissions collection (monthly A&E Sitrep). This monthly data return is expected to follow the current guidance. In short this means that activity should only be counted for unplanned attendances at Type 1 and Type 2 emergency departments and Type 3 and Type 4 departments, such as minor injury units, urgent care centres and walk-in centres. Activity should be reported by the provider with clinical responsibility. The one exception is when a Type 3 or Type 4 service from a different provider is co-located on the same site with a Type 1 A&E unit. In this circumstance the Type 1 provider should report the activity and performance from this co-located provider as part of its main return.

Non-co-located Type 3 activity has been, and continues to be, reported and published as a separate and identifiable entity.

Separate collection of new urgent and emergency care pathways

Any new emergency care pathways should be reported to the new UEC Pathways return This return asked NHS Trusts with Type 1 or Type 2 departments to give information on any UEC pathways that had previously been reported in the monthly A&E return, as a result of the NHSI letter in October, or any other UEC pathways.

The return asked the following questions:

Service Provider
Site
Service Description
Service Type (e.g. Type 1, Type 2, Type 3)
Was this activity previously reported on sitreps
Number of patients seen by the service
Number of patients seen within in 4 hours
Is this activity recorded in the trust information system
Can you identify the clock start for the patient pathway
Can you identify the clock stop for the patient pathway
Can you flow the data through SUS
If the data does flow through SUS, in was CDS does it flow (A&E/ECDS, Inpatient, Outpatient)
If the data does not flow through SUS is there a plan to do this

Following a review of the data, follow up questions were asked of some providers. This included clarification on whether the activity was previously reported to daily or monthly sitreps and whether the activity was still included in the monthly A&E return.

Annex B: Previous correspondence relating to A&E national performance reporting.

Letter from NHS Improvement to NHS Provider CEOs (13 October 2017)

NHS Improvement

Chief Executive and Chairman's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

BY EMAIL
13 October 2017

To: All NHS provider CEOs

Dear colleague

Clinical escalation plans and activity counting on UEC pathways

Thanks for all of your efforts to get on top of things in ED and prepare for a potentially difficult winter ahead. Pauline Philip has written to set out the plan, actions, next steps etc, and I wanted to seek your help with a couple of things as part of this.

Clinically-led escalation plans

I am sure you will have seen Ted Baker's comments in the media recently and read Pauline's letter yesterday about the need for clear escalation plans outlining what will happen at times of peak pressure. We need Boards, led by medical directors and nurse directors, to consider all of the options available to them and make decisions that weigh risk up in the round – especially to avoid caring for patients in corridors or preventing ambulance handover waits.

Being explicit about escalation will help your teams to pull in the same direction during peak periods, and to flush out any trade-offs that may need further thought. We will send more details soon on the operation of the National Emergency Pressures Panel, so that you can align your plans with nationally-recommended responses. In the meantime, I would be grateful if you could set this ball rolling within your organisation now and our Regional colleagues are keen to help if you need it.

Capturing unreported activity

There still appears to be substantial variation in the way urgent care activity is captured – indeed, several examples have been highlighted by CEOs over the last few days.

There are two particular issues. The first relates to the very effective new services for the elderly and/or ambulant patient – these provide excellent and timely care but are often completely absent in ED reporting. We must ensure that alternative pathways to A&E have not created areas of hidden waits, and that users of these services are managed to the same four hour standard, and A&E rules, as they would have been had they attended A&E. Most of the services I have seen actually provide more rapid access but don't record it. Some providers are managing to capture and report this data in their A&E reporting and it is clear to me that this is possible as long as certain conditions are met. Failure to do this results in data inconsistency and can also materially distort your performance, which will therefore not provide an accurate reflection of the service you are offering.

We will shortly write to you with more information to outline some of the practices we would suggest can be adopted, as well as reviewing the current guidance to see how this could be updated to ensure this activity is correctly recorded. In the meantime, as a set of guiding principles to aid your own work on this matter, activity should be counted within your A&E reporting data (Type 1, 2, or 3) if:

- the pathway involves a clinical or administrative process within the relevant hospital or associated site within the local urgent system, which supports access to and provision of urgent care
- patients should expect to receive care within four hours, as they would in an A&E department, and you would expect to start and stop a 4 hour clock on these patients
- the service / pathway is on the relevant hospital / associated site within the local urgent care system AND in the absence of the service / pathway, you would expect a corresponding increase in A&E activity.

All such activity should be reported consistently across daily and monthly SITREPs and SUS (including ECDS).

Reporting performance for Minor Injury Units / Walk In Centres

Secondly, I know that there is also a lack of consistency about how Type 3 activity is captured (principally within Minor Injury Units / Walk In Centres). The way this activity is collected currently depends on whether the unit is co-located or not, which means that some of you are being held to account for performance that is reported on a different basis to neighbouring trusts.

I would like to address this issue, but we want to avoid making changes to the way data is submitted by local organisations. Instead, if you can demonstrate agreement with all relevant local parties, including your Local Delivery Boards, we will allocate Type 3 activity on co-located / non-co-located sites in line with these local agreements, for performance reporting purposes.

What we can do to help

There are clearly things that you want us to do more or less of nationally – for example relating to workforce gaps, support and alignment from Colleges and other national bodies, issues relating to social care, reduction in reporting requirements and assurance. We are dealing with the issues raised but if there is something you feel we need to be dealing with to help you, please let myself or Pauline know directly, or provide feedback via your RD.

Thanks again for your continued effort and support. Keep going...

Yours sincerely

Jim Mackey
Chief Executive, NHS Improvement

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Appendix A

Having identified activity that you feel should be counted in your A&E reporting data (Type 1, 2, or 3), we and NHS England are likely to take the following lines of enquiry when considering whether the activity can be included in the data:

- Can you identify and record the clock start for the patient pathway?
- Can you identify and record the clock stop when the patient is either discharged, transferred or admitted? Please note that the start of treatment does not stop the clock.
- Can you flow the data through the relevant central returns (daily SITREP, monthly A&E data collections)?
- Can you flow the data through SUS? If not, do you have plans to flow the data through SUS as we move towards SUS being the primary source of such information?

[Letter from UK Statistics Authority to NHS England (22 January 2018)]

Letter from NHS Improvement to NHS Provider CEOs (25 January 2018)

NHS Improvement

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

BY EMAIL
25 January 2018

To: All NHS provider CEOs

Dear colleague

Activity counting on UEC pathways

I am writing to follow-up on Jim Mackey's letter of 13 October regarding variation in the way that urgent care activity is captured.

Clinical practices in urgent and emergency care have evolved in recent years, and many of you offer new services that provide enormous benefits to patients in terms of their experience and the quality and timeliness of care they receive. We must ensure that these 'new' pathways for emergency care are appropriately reflected in local and national data.

To do this, we need to collectively identify new pathways, assess local systems' ability to measure the activity and waits associated with these pathways, and agree, based on a set of consistent principles, whether these should count towards the current A&E target. I am grateful for the work that you have done to make progress on this front since October, and would like to outline our next steps to take this work forward.

Attribution of non-co-located Type 3 activity

The October letter outlined an approach to address the long-standing lack of consistency about how Type 3 activity is counted within local performance measures, which currently depends on whether the unit is co-located or not. This means that some of you are being held to account for performance that is reported on a different basis from neighbouring trusts.

I would like to reiterate the point that was made in this letter – namely, that there should be no changes to how non-co-located Type 3 data is submitted / reported by local organisations. Instead, and in addition to the traditional reporting of A&E performance, NHS England is now publishing a further set of figures, in which non-co-located Type 3 activity is attributed and mapped to the relevant Type 1 provider.

You should inform the NHS England data team of any changes that you would like central teams to enact. This should be based on an attribution that has already been agreed with regional teams.

These steps will ensure that attribution does not result in any double counting of activity and that there is no net impact on national performance.

Capturing new activity

Since the central data return is aggregate in nature, it is difficult to understand in every case whether changes in reported data since our October letter reflect activity patterns in 'existing services', or are instead the result of reporting on new services.

It is extremely important that local and national A&E data accurately reflects evolving clinical practices. We must also maintain the integrity of A&E attendance data, which is used to understand the pressures you are under, and ensure that we can understand and explain how this data has changed over time. We will be running a formal exercise from February to understand the detail of any new activity that may be submitted and how this fits with current guidance.

Until the exercise above has been completed, I would ask that any new areas of activity that are already being included in your submission as a result of our October letter should be submitted as a separate return, starting with your January data return. Your main return should contain the traditional Type 1, 2, 3 and 4 activity, and any new activity should be submitted in a separate return, the format for which will be sent shortly via your normal NHS England or NHS Improvement data contacts.

We will be in touch shortly with more details of next steps. These will include a more detailed set of guiding principles outlining practices we would suggest can be adopted, to support you in your local decision-making and to help us understand the nature of any proposed changes. In the meantime, I would be grateful if you could cascade this letter to the relevant teams in your organisation as soon as possible, so that they have time to enact any changes in time for the deadline for the January data submission in early February.

Thanks again for your continued effort over the past few weeks – I am aware that it has been a challenging period and that you and your staff have made enormous efforts for patients.

Yours sincerely

Ian Dalton CBE
Chief Executive, NHS Improvement

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

[Letter from NHS England to UK Statistics Authority (7 February 2018)]